Neogen Psychiatry, P.A.

Child, Adolescent and Adult Psychiatry
2141 Kirkwood Blvd, Ste 130, Southlake, TX 76092
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CONSENT FOR TREATMENT

PATIENT NAME: _____ _____
Last First Middle Date of Birth

For Patients Under 18 years of age:

I certify that I am the Father Mother Legal Guardian
(Circle One)

of the above-named child and I hereby give my authorization and consent for the above-named child to receive Psychiatric Outpatient Diagnostic and Treatment Services.
This includes use of “Off Label” Medications.

Father: _____Date: _____

Mother: _____ Date: _____
OR
Legal Guardian: _____ Date: _____

For Patients Over 18 years of age:

I certify that I am the patient named above and I hereby give my authorization and consent to receive Psychiatric Outpatient Diagnostic and Treatment Services. This includes use of “Off Label” medications.

Signature: _____ Date: _____